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SOCIOLOGICAL ASPECTS OF PERSONALITY CHANGE--A STUDY OF MENTAL HOSPITALIZATION.

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A STUDY OF MENTAL HOSPITALIZATION WAS MADE IN A UNIVERSITY-AFFILIATED, ACTIVE-CARE STATE INSTITUTION CONCERNED MAINLY WITH SCHIZOPHRENICS. THE AUTHOR EXAMINED THE ROUTES PATIENTS FOLLOW THROUGH THE HOSPITAL IN RELATION TO THERAPY AND THE PATIENT'S RETURN TO OUTSIDE LIFE. HE OBSERVED THAT THE PATIENT'S SOCIAL POSITIONS ARE DEFINED IN LARGE PART BY STATE LAW, AND THAT NEWLY ADMITTED PATIENTS MAY OCCUPY A COURT POSITION, A JUDICIALLY COMMITTED POSITION, A TEMPORARY OBSERVATION STATUS, OR A VOLUNTARY ONE. THE AUTHOR PROPOSED THAT AN ORGANIZATION'S STRUCTURAL CHARACTERISTICS ARE RELATED TO THE TYPES OF ACTIVITIES CARRIED ON BY ITS MEMBERS. THE DYADIC PSYCHOTHERAPEUTIC RELATIONSHIP WAS EXAMINED IN TERMS OF THE OBJECT, OR ENTITY ACTED UPON, THE SOCIAL RELATIONSHIP INVOLVED, AND THE NORMS EXPECTED IN PERFORMANCE. THE TREATMENT PROCESS WAS SEEN AS A SERIES OF PSYCHOLOGICAL CHANGES WHICH ARE INITIATED BY THE DOCTOR AND HIS PATIENT, AS WELL AS CHANGES IN THEIR RELATIONSHIP TO EACH OTHER, AND THE RELATIONSHIP BETWEEN THIS DYAD AND THE ORGANIZATIONAL SETTING. THE PATIENT'S SOCIAL RELATIONSHIP, DETERMINED IN PART BY THE NATURE OF THE POSITION HE OCCUPIES, WAS DESCRIBED AS BEING SOMEWHAT CONDUCIVE TO ESTABLISHING TRUST, AND TO HELPING THE PATIENT ESCAPE HIS POTENTIALLY STRESSFUL DAILY LIFE AND RETURN TO THE OUTSIDE LATER THROUGH THE RESOURCES OF THE THERAPIST. A NEED WAS SEEN FOR CONCEPTUALIZING BOTH THE ELEMENTS OF ACTIVITIES AND THE PROPERTIES OF SOCIAL POSITIONS IN THEIR OWN RIGHTS RATHER THAN AS MERELY SLOTS IN A SOCIAL SYSTEM. THE AUTHOR SUGGESTED THAT FURTHER PSYCHIATRIC RESEARCH TAKE INTO ACCOUNT THE ORGANIZATIONAL PROPERTIES OF TREATMENT SETTINGS AS WELL AS TRADITIONAL PSYCHODYNAMIC FORMULATIONS. THIS PAPER WAS PRESENTED AT THE ANNUAL MEETING OF THE AMERICAN SOCIOLOGICAL ASSOCIATION (61ST, MIAMI BEACH, AUGUST 31, 1966). (TC)

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SOCIOLOGICAL ASPECTS OF PERSONALITY CHANGE: A STUDY OF MENTAL HOSPITALIZATION

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Sociological Aspects of Personality Change: A Study of Mental Hospitalization

This paper concerns some neglected questions in the sociological study of deviance: in particular, the psychiatric treatment of mental illness. It is much easier to define deviance by example than to offer a general formulation capable of distinguishing deviant actions and thoughts from other kinds. There are forms of mental illness that involve marked failures to meet conventional role obligations, and involve both behavior and mental functioning sufficiently disruptive that there is widespread agreement that such illness represents deviance. Even though it is difficult to draw a sharp distinction in the abstract between deviance and non-deviance, such distinctions are made daily, justifiably or not; and if an individual is judged to be deviant enough, social processes, restorative in their intent if not always in their result, are put into effect. One such process is mental hospitalization.

There are several ways to consider the social arrangements designed to restore mentally ill persons to psychological health and social participation, and as in other areas of investigation, the approaches have been governed by somewhat distinct perspectives that illuminate some aspects of a phenomenon and inevitably leave others in relative darkness. It is not possible to review relevant literature in a discussion as brief as this; instead, I shall employ one particular formulation to raise several issues relevant both to the practice of psychiatric treatment and to the sociological analysis of social roles, large-scale organizations, and personality change.

The idea that psychiatric treatment can be understood as a sequence of phases is not new. Freud, for one, described the psychological qualities of the phases of private analytic therapy; others have viewed mental hospitalization as a sequence of events. In one recent formulation, Goffman describes a three-stage process of mental hospitalization: pre-patient, inpatient, and ex-patient.[1] In reality, it is often difficult to cut this process up into such neat pieces since there are aspects of the treatment process that do not follow a simple time sequence. Be that as it may, Goffman's narrative ends, sadly, both for the patient and for sociology, with the second phase.[2] Granted that some patients never leave a hospital once they are committed, or gravitate back as patients or employees once they are discharged, one major concern of staff members in active-treatment hospitals is precisely that of preventing patienthood from becoming a career.

From a sociological perspective, characteristics problems in the operation of mental hospitals have their counterparts in families, schools, colleges, and prisons: establishing the membership of persons, bringing about their adaptation to the social setting in order to effect psychological changes in them, and producing changes permanent enough to endure beyond the termination of membership. There is a paradoxical aspect to these problems clearly illustrated in mental hospitals. The patient should become adapted to the hospital in such a way that he can remain outside of it following his discharge. He must immerse himself in hospital life sufficiently to participate in treatment but no so deeply

that his discharge becomes impossible. A mental hospital is not supposed to work like a religious seminary or an officers' candidate school, and to the extent it does, it has failed in its task.[3] Thus, Goffman's patient for whom mental illness is a career has become a convert to mental hospitalism.

This paper contains findings from an investigation of mental hospitalization in which evidence was found for a sequence of stages having no direct resemblance either to those described by Goffman or to those reported in the psychoanalytic literature referring to intrapsychic changes. Rather, it appeared that patients entered, passed through, and left the hospital as occupants of a series of social positions whose characteristics were defined at least in good part by state law.

The hospital in question is an active-care institution with a major though not exclusive interest in the psychotherapeutic treatment of schizophrenic patients. It is a university-affiliated training hospital and part of the state system.[4] In the remainder of this paper, I shall describe these positions and the dominant sequential arrangements among them as they relate to the nature of therapeutic activity and the patient's return to life in the outside community.

Characteristics of Hospital Positions

The routes patients follow through the hospital begin with the following four entrance positions each demarcated by certain legal characteristics:

1. Court position:[5] occupied by patients sent by a district court judge for psychiatric evaluation as to capacity to stand trial. Such patients fall under court jurisdiction even while hospitalized; they can be kept no longer than 35 days -- about 10 days is usual -- after which the hospital must return them to court.

2. Judicially committed position:[6] occupied by patients who are incarcerated subject to both medical and legal judgment, without stipulation as to length of stay.

3. Voluntary position:[7] occupied by patients who enter without stipulation as to length of stay, but with the right to leave after giving the hospital three days notice.

4. Temporary observation position:[8] occupied by acutely ill patients who are hospitalized for no more than 10 days of observation unless transferred into another legal status, sent either by a physician or an officer of the law. It is the most frequently used path of hospital entrance for patients who remain for treatment.

Passage through the Hospital: The Sequence of Positions

Although patients can be admitted to the hospital through any one of these four positions, they can remain for treatment beyond a very brief period only as voluntary or judicially committed patients, or as occupants of a fifth transitional position with a maximum length of stay restricted to 40 days.[9]

Among the 609 admissions[10] during the year studied, there were five patterns, empirically discovered, by which patients moved through the hospital, position by position.

1. Of this number, only 11 (1.8% of the total) entered by judicial commitment, an indication that the hospital admits very few patients whose incarceration requires the combined coercive force of both medical and legal sanction.

2. Of the 210 patients sent by the courts (amounting to 34.5% of total admissions), 208 (99.0%) were returned to court, pursuant to state law. Nine were kept for very brief treatment while still court cases; by special arrangement involving dismissal of criminal charges, two of the nine remained on a voluntary basis without being returned to court. Court cases, thus, are rarely kept for treatment remaining as they do within the court's jurisdiction.

3. Of the 92 voluntary admissions (15.1% of the total), 90 (97.8%) remained in the hospital on a voluntary basis and were discharged without change in legal status. (The other two were judicially committed.)

4. Of the 296 acute admissions present for 10 day observation (48.6% of the total), 179 (60.5%) became voluntary patients during their hospitalization.[11] Of these 179 all but one were discharged from the voluntary status.

5. Of the 272 patients who <u>at any time</u> during their stay occupied a voluntary position, regardless of how they first entered, 269 (98.9%) were discharged from that status.[12]

The hospital, even though part of the state system, has the authority to select its relatively long-term non-court patients, and within this

selected group, to determine which ones shall participate in psychotherapy. It does not retain the vast majority of patients whose admission is officially coerced: those entering on judicial commitments and those sent by the courts (who must be returned). Most important for the present discussion, as indicated by the above trends, the hospital affords patients the opportunity to enter treatment as voluntarily as possible: by admitting them as such or by transferring them into a voluntary position after evaluation.

Whatever occurs inside the patient during treatment, one can view hospitalization not only in psychological terms but also as the passage of patients from position to position where each one has different structural characteristics. Psychodynamic formulations of therapy, however, do not take into account variations in the organizational structure of the treatment setting as defined by state law; the same applies to formulations like Goffman's, concerned as they are with temporal sequence and with the assault on personal identity.

The Relationship between Treatment and the Sequence of Positions

Analytically-oriented therapy developed and flourishes primarily as an activity carried on by a doctor and a patient in isolation from customary social contacts. When people become so ill that they cannot cope with the daily round of events and cannot be treated on an ambulatory basis they are hospitalized. In hospitals that can reasonably call themselves treatment-centered rather than custodial, psychiatrists attempt

to preserve many of the properties of the two-person therapeutic relationship within the confines of an organizational setting. The private office within the larger hospital setting rather than the private office alone constitutes the environment in which treatment activities take place. The evidence presented here suggests that in the attempt to restore an ill person to health and to life in the community, the treatment process consists of psychological changes brought about not only through the joint participation of doctor and patient, but through changes both in the relationship between doctor and patient, and in the relationship between that dyadic unit and its organizational surroundings. To define one type of linkage between an organization and its parts, I propose the following proposition: the structural characteristics of an organization[13] are related to the nature of the activities its members engage in. It is necessary, then, to define the concept of 'activity.'

There have been many investigations of different kinds of work but few attempts to conceptualize its component activities.[14] In this paper I am concerned with three of the many possible dimensions of activities -- the one in question here being psychotherapy -- in order to interpret the particular pattern of hospital operation described above.

First, the object: the entity acted upon.

Second, the social relationship: the arrangement and characteristics of social positions occupied by those engaged in the activity.

Third, norms: the premises pertaining to how the participants should act in performing the activity.

The object is the patient;[14] more specifically, certain characteristics associated with schizophrenic illness (at least in this hospital). By identifying the patient as the object, however, I do not imply that the patient is a passive agent; the contrary is (or should be) the case. Not only is the doctor expected to act so as to bring about changes in the patient, the latter is expected to do likewise, but not to change the doctor. One important characteristic of these patients is that they are withdrawing from social existence; contact with people produces terrible anxiety and distrust, and they are in great psychological pain.

The social relationship in which psychotherapy takes place consists primarily of two positions: a dyad. This is not to suggest that the hospitalized patient has contact with only one person. Whether or not a two-position arrangement is actually efficacious -- there are dissenting voices on this point[15] -- in fact it constitutes the immediate setting in which treatment takes place; literally so in private therapy, and with limitations in a hospital setting.

If Simmel[16] is correct, a dyad is a type of relationship most conducive to the development of intimacy and privacy; at the same time, the potentiality for its members to establish a sense of trust between themselves, so important for the treatment of schizophrenics, may be jeopardized by the involvement of third parties.

Much has been written about norms pertaining to doctors and patients in therapeutic situations;[17] of primary interest here are the expectations that patients acknowledge their need for treatment and assume the

responsibility to "work" at getting well even though it hurts; and that doctors, through word and action, communicate that they care about and can be trusted by their patients.

With these characteristics of the object, social relationship, and norms in mind, consider the predominant trend by which patients remaining hospitalized for treatment move into and remain in a position legally defined as voluntary even if their status at the time of admission was non-voluntary. The term "voluntary" refers not to an individual making a "free" choice among alternatives, but rather to the property of a social position that provides a patient with the opportunity for the greatest possible independence of choice among the available alternatives, either to leave the hospital or to remain and participate actively in getting well; independence, in that legal and medical sanctions are least intense in this position compared to the others.[18]

What, then, is the relationship between psychotherapeutic activity and the voluntary position? First, as to the patient and his illness: occupying this position reduces the likelihood that he can justifiably view entrance into treatment as the result of collusion between his family or friends and the therapist. For a person who finds contact with people painful, being forced into a relationship through medical or legal sanction may arouse anxiety of sufficient intensity to perpetuate an already weakened capacity to trust.

Second, as to the social relationship: on the one hand, by entering a dyadic relationship with relative freedom, the patient intentionally separates himself to some degree from painful alliances to work at

reentering the world of public existence by establishing contact with one, hopefully safe, individual. On the other hand, whether or not the patient occupies a position has implications for the doctor's actions. For example, with psychotic patients coming from the court where the court represents a coercive third party holding legal jurisdiction over them, the hospital, through the agency of the therapist,[19] is legally obliged to report its findings about the patient to the court. The therapist, therefore, has a double obligation; the patient, whose troubles include a criminal indictment in addition to his illness, is likely to harbor doubts as to where the therapist's primary obligation lies: to him or to the court.[20]

Third, as to norms: entering a voluntary position tends to symbolize the patient's acknowledgement of his illness, his trust in the doctor, and his willingness to accept the obligation to work at getting well. The therapist who can justifiably claim that <u>he</u> is not keeping the patient hospitalized can communicate credibly to the patient that he cares about him. Although the presence of these aspects of treatment activities and their setting do not guarantee the patient's return to health, the alternative arrangements available in the hospital appear, in contrast, inimical to carrying on therapeutic activities with schizophrenics (given the current state of the art).

Fourth, since entering a voluntary position signifies at least the patient's minimal acceptance of the injunction to participate actively in his own treatment, he sets himself against the more engulfing influences of hospital life: the sameness of the environment, the

regulation of daily existence, and the continual experience of being taken care of, all of which may lead to continual dependence on the hospital -- careerism. Given the current state of psychiatric technology for treating schizophrenia, the availability of the voluntary position represents one resource by which patients can adapt to the hospital environment for a prolonged period and still leave it subsequently,[21] for they retain more power to regulate their environment both in treatment and in hospital life than would be available to them as occupants of other more coercive hospital positions. Perhaps considerations of this kind account in part for findings, such as those reported by Freeman and Simmons, that "patients legally committed [i.e., judicially] were much more likely to return regularly to the hospital for out-patient treatment than were those with voluntary commitments."[22]

Implications

Concerning psychiatric practice, the relationship between the characteristics of patients, treatment activities, and aspects of the organization suggests that further psychiatric research might well consider the organizational properties of treatment settings as well as the more traditional concerns with psychodynamics. Recent studies of both mental hospitals and prisons provide substantial support for this contention.[23]

In sociological terms, the findings of this paper have implications both for the analysis of social roles and of organizational structure. There is a need to conceptualize both the elements of activities (as one way of viewing role behavior), and the properties of social positions

in their own right rather than simply as locations or slots in a social system. In the context of this inquiry, two of the important characteristics of the patient's social position are its conduciveness to the establishment of trust and the opportunity it provides the patient both for extricating himself from a potentially engulfing situation by and for returning to the daily round of work and family life by using the resources available through his relationship with the therapist.

Although these particular characteristics may be unique to positions in mental hospitals, or even to active-treatment hospitals governed by the laws of Massachusetts, they also represent aspects of social phenomena more general in scope. Agencies of personality change other than mental hospitals have their portals of entrance and exit between which one finds more or less formally demarcated social positions, having characteristic properties, and arranged in sequential order. The arrangement of public schools into grades and levels, of colleges and professional schools into their well-known years and stages bears striking resemblance to the legally-defined phases of hospitalization.

Those being subject to the forces of change in each setting form characteristic relationships with persons attempting to change them, relationships that vary in nature with each change in position, and with successive phases more closely approximate the type of relationship desired at the destination.

In organizational terms, variations in treatment activities related to the legal status of patients can be understood as one manifestation

of the more general principle that the chances of performing activities successfully depends on the properties of the social positions, and the relations between them, occupied by those performing the activities.

Footnotes

1. Erving Goffman, "The Moral Career of the Mental Patient," in Asylums, (New York: Anchor Books, 1961), pp. 130-131.

2. For a critique of the simple time sequence approach in which phases have clear boundaries, see Howard E. Freeman and Ozzie G. Simmons, The Mental Patient Comes Home (New York: John Wiley and Sons, Inc., 1963), p. 197. Unlike Goffman, these writers treat the expatient or post-hospital phase as problematic.

3. In his papers on total institutions and mental patients, Goffman has portrayed hospitals in the process of failing. Regrettably, his conceptual tools appear to be limited to this type of portrayal and not adequate for taking into account a variety of outcomes. It is necessary to keep in mind, however, that there are types of mental illness for which a custodial hospital is probably still a necessity and other types for which the available treatment technology is insufficiently developed. In these cases, one cannot legitimately speak of the failure of hospitalization.

4. During the two years (1959-61) when the field work was carried out, the hospital had about 120 beds. Its staff members devote themselves to research in medicine and the behavioral science as well as to training and patient care. Data for the study were gathered from the case records of all patients admitted to the hospital for a period of one year. Not all patients are schizophrenic -- a large minority -- but the hospital attempts to establish a climate congenial to the treatment of these

patients, a climate that is not necessarily suited to treating certain other types of illness. Robert Dreeben, "Organization and Environment: The Relationship between Mental Hospital and District Courts," unpublished Ph.D. dissertation, Harvard University, 1962.

5. Massachusetts General Laws, Chapter 123, Section 100.

6. Ibid., Section 51.

7. Ibid., Section 86.

8. Ibid., Section 79.

9. Ibid., Section 77. The hospital alone has the right to make this transfer. Patients are transferred onto a Section 77 only from a Section 79.

10. Actually, the unit of description is the 'admission,' not the patient. I selected this unit for technical reasons as the best way of classifying patients who were admitted, discharged, and readmitted during the calendar year of the study. The 568 patients studied accounted for 609 admissions. See Dreeben, op. cit., pp. 48-49, for a more complete discussion of the considerations involved in making this choice of descriptive unit.

11. Either directly from Section 79 to Section 86, or indirectly from Section 79 to Section 77 to Section 86.

12. Discharge may mean either return to the community, to the court, or to another hospital. For this discussion, the important thing is that discharged patients are not kept in this hospital whatever their destination may be. The number transferred to another hospital from Section 86 was very small.

13. I make no attempt here to describe all the relevant aspects of hospital structure, but only those aspects most germane to this discussion.

14. Several studies representing notable exceptions to this generalization in that they do contain adequate conceptualizations of activities are the following: Arthur Stinchcombe, "Bureaucratic and Craft Administration of Production: A Comparative Study," Administrative Science Quarterly, Vol. 4, No. 2, September 1959, pp. 168-187. Charles R. Walker and Robert H. Guest, The Man on the Assembly Line (Cambridge: Harvard University Press, 1952). Alvin W. Gouldner, Patterns of Industrial Bureaucracy (Glencoe: Free Press, 1954).

15. Spiegel, John P., "Some Cultural Aspects of Transference and Counter-transference," in Jules H. Masserman (ed.), Individual and Familial Dynamics (New York: Grune and Stratton, Inc., 1959), pp. 160-182.

16. Georg Simmel, Sociology, (Glencoe: Free Press, 1950), pp. 118-169.

17. Talcott Parsons, The Social System (Glencoe: Free Press, 1951), pp. 428-470.

18. Although state law makes it possible for the patient to be judicially committed when the patient gives the hospital three days notice of his intention to leave, psychiatrists seldom invoke the law. Doing so is viewed as poor psychiatric practice reflecting on the psychiatrist's judgment in moving the patient into a voluntary status in the first place.

19. Legally, the hospital Superintendent is responsible for meeting the obligation to report on the patient to the court; actually, the psychiatrist who has cared for the patient in the hospital makes recommendations to the court and these are very seldom overruled by the Superintendent.

20. It is interesting that of the 49 court cases diagnosed as psychotic, only 9 (18.4%) were kept in the hospital for treatment. Two of the nine were transferred into a voluntary status by special arrangement; residents responsible for the other seven all spoke of special treatment difficulties traceable to the court origins of these patients. There are other elements of hospital structure in addition to the voluntary position that enable psychiatrists to reduce the number and intensity of obligations that conflict with those he holds to the patient.

21. This contention only holds in reference to the current state of psychiatric knowledge and practice. Conceivably, future developments could render the substance of these arguments invalid.

22. Freeman and Simmons, op. cit., p. 80.

23. See, for example, Donald B. Cressey, "Limitations on Organization of Treatment in the Modern Prison," in Richard A. Cloward, et al, Theoretical Studies in Social Organization of the Prison, (New York: Social Science Research Council, 1960), Pamphlet 15, pp. 78-110; Stanton Wheeler, "The Structure of Formally Organized Socialization Settings," in Orville G. Brim, Jr. and Stanton Wheeler, Socialization After Childhood, (New York: John Wiley and Sons, Inc., 1966), pp. 53-116;

Robert N. Rapoport, Community as Doctor (London: Tavistock Publications, 1960); and Spiegel, op. cit. In the hospital discussed here, patients whose illness presents treatment and maintenance problems potentially disruptive to therapeutic activity with schizophrenics are admitted in relatively small numbers and are readily transferred out of the hospital. Members of the staff are not sanguine about treating patients diagnosed, for example, as personality disorders because of concern that they cannot trust these patients; among psychotics, it is the patients who tend to be distrustful. What is more, hospitals designed to treat personality disorders are organized on a basis markedly different from the present one, as shown, for example, in Rapoport's study of the Social Rehabilitation Unit of Belmont Hospital in England.

Appendix: The Sequences by Which Patients Move through The Hospital in Legally-defined Statuses (July 1, 1959 to June 30, 1960)[a/]

Total Admissions: N = 609

A. Admissions entering on Section 79 (N=296)

Second Status	N	%
77[b/]	141	47.6
86[c/]	112	37.8
51	2	0.7
Discharged from 79	41	13.9

1. Admissions whose second status is Section 77 (N=141)

Third Status	N	%
86	66	46.8
51	39	27.7
Discharged from 77	36	25.5

a. Admissions whose third status is Section 86 (N=66)

Fourth Status	N	%
51	1	1.5
Discharged from 86	65	98.5

b. Admissions whose third status is Section 51 (N=39)

Fourth Status	N	%
Discharged from 51	39	100.0

2. Admissions whose second status is 86 (N=112)

Third Status	N	%
Discharged from 86	112	100.0

3. Admissions whose second status is Section 51 (N=2)

Third Status	N	%
Discharged from 51	2	100.0

B. Admissions entering on Section 86 (N=92)[d/]

Second Status	N	%
51	2	2.2
Discharged from 86	90	97.8

1. Admissions whose second status is Section 51 (N=2)

Third Status	N	%
Discharged from 51	2	100.0

C. Admissions entering on Section 51 (N=11)[e/]

Second Status	N	%
Discharged from 51	11	100.0

D. Admissions entering on Section 100 (N=210)

Second Status	N	%
86	2	1.0
51 and RC 100	16	7.6
To court on 100	192	91.4

1. Admissions whose second status is Section 86 (N=2)

Third Status	N	%
Discharged from 86	2	100.0

2. Admissions whose second status is Section 51 or Section RC (N=16)

Third Status	N	%
Discharged from 51 or RC 100	16	100.0

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a/ Massachusetts General Laws, Chapter 123.

b/ Includes Section 78 (N=9) and Section TC 77 (N=1), two rarely used statuses. For the sake of simplicity in presenting the table, and without distorting its meaning, these 10 cases are included with Section 77. Although they actually were discharged on 77 as a third status, they are included here among those 77's discharged on the second.

c/ Includes Non-statutory voluntaries (N=4)

d/ Includes Non-statutory voluntaries (N=2)

e/ Includes Section 77 (N=1); Section 77 is almost never used as an admission status. For this one exceptional case, it seemed most appropriate to include it among the committed patients.